

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

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07743

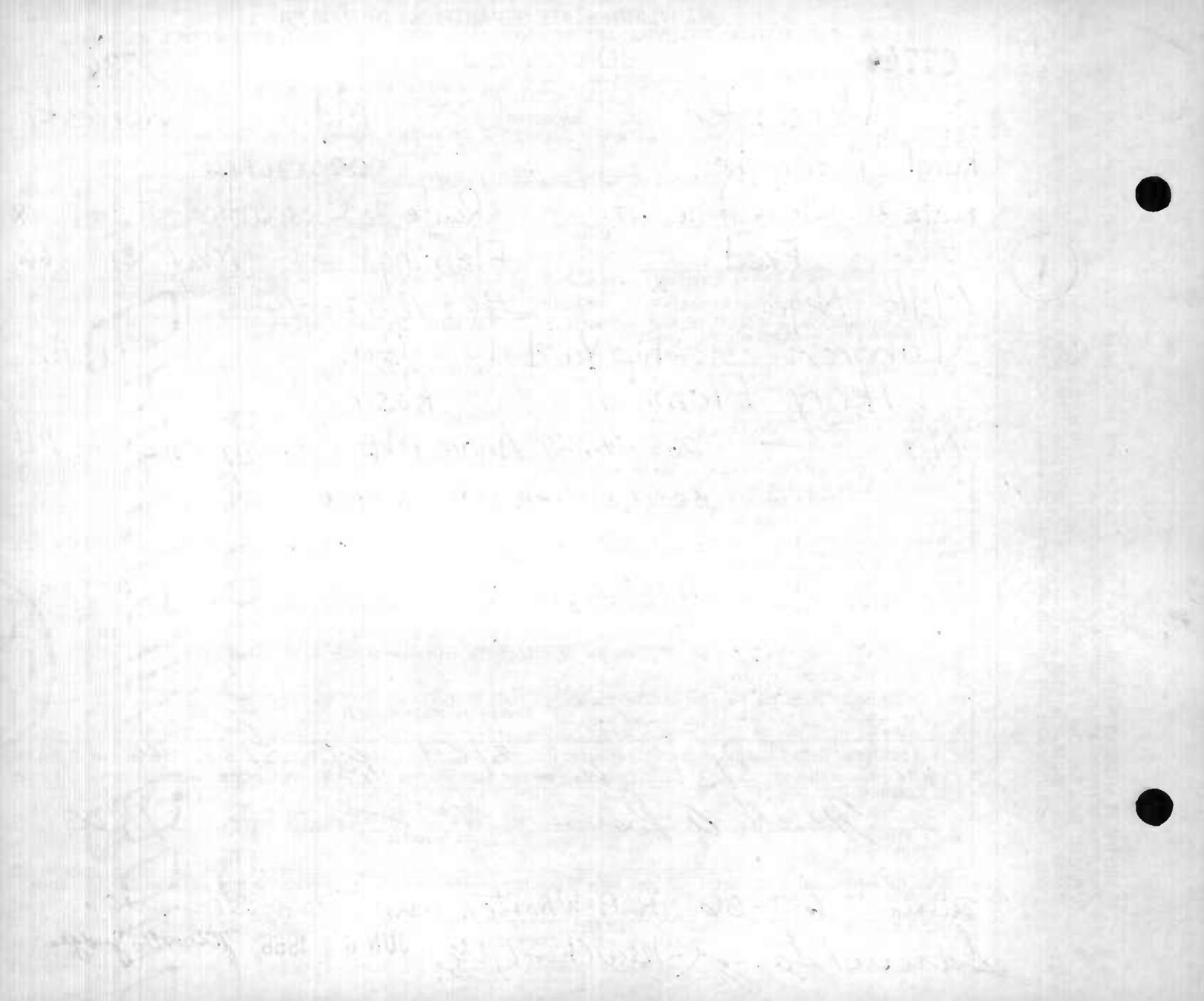
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07733

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in the event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		c. LENGTH OF STAY IN 1b 1 week		
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salesbury		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 608 Washington Lane		d. STREET ADDRESS 104 Benjamin Ave		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Raymond Lee	Middle D	Last Risecoll	
4. DATE OF DEATH	Month May	Day 30	Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Sept 6 1902 63	
9. AGE (In years (last birthday) yrs. 63	10. KIND OF BUSINESS OR INDUSTRY Refined - shirt maker	11. BIRTHPLACE (State or foreign country) Wicomico County	12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Joseph R. Risecoll	14. MOTHER'S MAIDEN NAME Lillie Rounds	Address Salisbury, Md.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 214-10-9071	17. INFORMANT Mrs. Ruth Risecoll (wife)	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH INSTANT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>F. J. Townsend, Jr.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED May 30, 66
EXAMINER'S NAME (Type)	Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, BURIAL Burial	23b. DATE THEREOF June 1/1966	23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY	ADDRESS SALISBURY, MARYLAND	25a. REC'D BY REGISTRAR JUN 6 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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FOR STATE
HEALTH DEPT.

Item 20 Film G377 6/6/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07745 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07735

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berlin Md.	d. STREET ADDRESS Spring Hill Rd.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Omar	First Harmon Middle Harmon Last Harman	4. DATE OF DEATH 5 25 1966				
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 13, 1907	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	11. IF UNDER 24 HRS Hours 0 Mins 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Timber work	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles	14. MOTHER'S MAIDEN NAME Harmon	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Nellie Harmon 706 Moor St. Salis Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal injuries 9108 DUE TO (b) Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Tree fell on him DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Tree fell on victim crushing him to the ground causing internal injuries and breaking both legs.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour 2:00 p.m. 5/25 1966	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Timber woods	20f. (City or town) Berlin	(County) Worcester	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Clifford E. Schott</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Clifford E. Schott, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
Address (Street, city, town, or county) Acting Worcester						
22. DATE SIGNED 5-25-66						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/29/1966	23c. NAME OF CEMETERY OR CREMATORIUM ST. Mayrs Church	23d. LOCATION (City, town or county) (State) West Post Office Md.			
24. FUNERAL DIRECTOR <i>Clifford E. Schott, M.D.</i>	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15ME 3500 4-64	DATE JUN 1 1966					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

07746

07736

1. PLACE OF DEATH
a. COUNTY

Worcester

MARYLAND

CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Sunn Hill

c. LENGTH OF STAY IN 1b

25 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)First
HaroldMiddle
W.Last
Parker4. DATE
OF
DEATH

May 1st

Month
Year

19 64

5. SEX

6. COLOR OR RACE

Male Negro

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 28, 1915

9. AGE (in years
last birthday)
50 yrs.10. IF UNDER 1 YEAR
Months Dey11. IF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Attendant

10b. KIND OF BUSINESS OR INDUSTRY

Serv. Station

11. BIRTHPLACE (State or foreign country)

Wendua, W. Va.

12. CITIZEN OF WHAT COUNTRY

W. S. C.

13. FATHER'S NAME

Victor Parker

14. MOTHER'S MAIDEN NAME

Marie Reid

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

220-16-7620

17. INFORMANT

Elizabeth Parker Sunn Hill, W. Va.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

8919 DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

8 hrs

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Acute Alcoholism (?)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fall step in car

20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 10 1 May 196620d. INJURY OCCURRED
While Not While at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)

(State)

Roat 113

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

David Rafat

EXAMINER'S
NAME (Type)

DAVID RAFAT

DATE SIGNED

5-4-66

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 5-07-66

22c. NAME OF CEMETERY OR CEMATORIAL
ADDRESS

Shiloh Bapt. Cemetery

22d. LOCATION (City, town, or county)
(State)

Wendua, W. Va.

23. FUNERAL DIRECTOR

O. C. Humbles Accoman, W. Va.

24a. REC'D BY REGISTRAR
24b. REGISTRAR'S SIGNATURE

MAY 6 1966 Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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07747

CERTIFICATE OF DEATH

07737

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berlin Nursing Home		d. STREET ADDRESS 23-1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Homer	Middle W.	Last Shockley
4. DATE OF DEATH May 4, 1899	Month May	Day 23	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH May 4, 1899
8. AGE (In years last birthday) 67 yrs.		9. BIRTHPLACE (County & State, or foreign country) Snow Hill, Maryland	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac W. Shockley		14. MOTHER'S MAIDEN NAME Theodosia E. Hales	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217102370	
17. INFORMANT Anna G. Shockley, Ocean City, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch. Myocarditis & Endocarditis DUE TO (c) Hypertension			
INTERVAL BETWEEN ONSET AND DEATH 3 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Snow Hill, Maryland
20f. (City or town) Snow Hill		(County) Maryland	
(State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from 5-5-1966 to 5-23-1966 , that (I) (we) last saw the deceased alive on 5-23-1966 , and that death occurred at Snow Hill , from causes and on the date stated above.			
22a. SIGNATURE Chas R. Law		22b. DATE SIGNED 5-25-1966	
22c. PHYSICIAN'S NAME (Type) Chas R. Law		22d. ADDRESS Berlin Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Zion Cemetery
23d. LOCATION (City or Town) Snow Hill, Maryland		(County) Maryland	
(State) Maryland			
24. FUNERAL DIRECTOR James F. Dennis		25a. REC'D BY REGISTRAR MAY 27 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
ADDRESS Snow Hill, Maryland			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

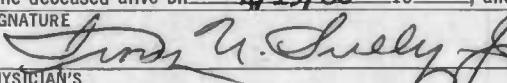
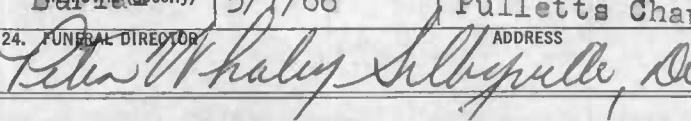
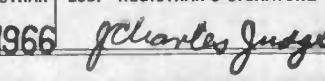
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07738

1. PLACE OF DEATH e. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Selina	Middle Smack
4. DATE DF DEATH May 6, 1966	Month May	Day 6	Year 1966
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1905
9. AGE (In years last birthday) 60 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Millie Jarman	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 219-07-9365		
17. INFORMANT Henry Smack Whaleyville, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Instant			
54 Yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Whaleyville attended the deceased from 11/28/59 , 19, to 4/15/66 , 19, that (I) last saw the deceased alive on 4/15/66 , 19, and that death occurred at 5 PM , from the causes and on the date stated above.	22b. DATE SIGNED 5/6/66		
22c. SIGNATURE 	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD	22d. ADDRESS P. O. Box 126, Berlin, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/3/66	23c. NAME OF CEMETERY OR CREMATORIAL Pulletts Chapel	23d. LOCATION (City, town or county) (State) Whaleyville, Md.
24. FUNERAL DIRECTOR 	ADDRESS	25e. REC'D BY REGISTRAR MAY 9 1966	25d. REGISTRAR'S SIGNATURE 
VR A15 (4) 15M 4-64			

Geographic Distribution

Author biography

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100 Years of the ILO

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07749

07739

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the "pending" certificate. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Ocean City		b. COUNTY Worcester	
c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elm Street		d. STREET ADDRESS Elm Street	
3. NAME OF DECEASED (Type or print) O'ferall		First	Middle
4. DATE OF DEATH Thornton		Month	Day
5. SEX Male		Year	
6. COLOR OR RACE W		7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-10-1896		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill work		10b. KIND OF BUSINESS OR INDUSTRY Mill work	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Thornton		14. MOTHER'S MAIDEN NAME S. Ella Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 221-09-0592	
17. INFORMANT Wm J. Thornton, Pennsgrove, N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound - Self inflicted		INTERVAL BETWEEN ONSET AND DEATH	
976X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Clifford E. Schott		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Clifford E. Schott, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting	
Address (Street, city, town, or county) Worcester			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-16-66	23c. NAME OF CEMETERY OR CREMATORIAL Sand Hill Cemetery
23d. LOCATION (City, town or county) Georgetown, Del		(State)	
24. FUNERAL DIRECTOR Anna A. Burbage		ADDRESS Berlin, Md.	25a. REC'D BY REGISTRAR MAY 17 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item #9 Form #8371 5/22/65 07740

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b All life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LILLIE	Middle TINGLE	4. DATE OF DEATH Month Day Year May 10, 1966
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Worcester	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Lillie Adams	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 213-18-5731		17. INFORMANT Ressie Holland Branch St, Berlin, Md	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Chronic nephritis (c) DUE TO Senility		3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/1/66 to 5/1/66 , 19, that (I) <input type="checkbox"/> last saw the deceased alive on 5/1/66 19, and that death occurred at AM , from the causes and on the date stated above.		22b. DATE SIGNED 5/11/66	
22a. SIGNATURE Ivory U. Sully, Jr., MD		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/11/66
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS P. O. Box 126, Berlin, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-14-66	23c. NAME OF CEMETERY OR CREMATORIAL Evergreen
24. FUNERAL DIRECTOR Loretta B. Josley - Jersey Rd. Salisbury		ADDRESS Salisbury	25a. REC'D BY REGISTRAR DATE MAY 19 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07751

CERTIFICATE OF DEATH

07741

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		b. COUNTY Worcester	
c. LENGTH OF STAY IN 1b 28 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Golf Course Rd.</i>		d. STREET ADDRESS Golf Course Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James B. Whaley		First	Middle
4. DATE OF DEATH Month May	Day 22	Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH April 10 1893	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager	10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.	11. BIRTHPLACE (County & State, or foreign country) Whaleyville, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benton H. Whaley	14. MOTHER'S MAIDEN NAME Edna Staton	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Emily U. Whaley, Ocean City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ASCVI		INTERVAL BETWEEN ONSET AND DEATH Recent	
DUE TO (b) DUE TO (c)		ASCVI with coronary sclerosis 6 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Debilitating			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Whaleyville
20f. (City or town) Ocean City		(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19, to May , 1966, that (I) (we) last saw the deceased alive on Dec. 16 1966 , and that death occurred at 9A M, from causes and on the date stated above.			
22. SIGNATURE <i>John Townsend Jr.</i>			
22c. PHYSICIAN'S NAME (Type) F. J. Townsend, Jr.		22d. ADDRESS Ocean City, Md.	22e. DATE SIGNED May 23, 66
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/66	23c. NAME OF CEMETERY OR CREMATORIAL Whaley Cemetery
24. FUNERAL DIRECTOR <i>James F. Whaley</i>		ADDRESS Snow Hill, Maryland	25a. REC'D BY REGISTRAR MAY 27 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

STATION 31, X-1951

1270

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07752		07742	
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Bishop c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Stage Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY WOR. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bishop d. STREET ADDRESS Old Stage Road.	
3. NAME OF DECEASED (Type or print) Delmar James Wilkins First Delmar Middle James Last Wilkins		4. DATE OF DEATH Month May Day 4 Year 1966	
5. SEX M		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28 1916	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) weighmaster		10b. KIND OF BUSINESS OR INDUSTRY chicken	
11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James Wilkins		14. MOTHER'S MAIDEN NAME Edna McCabe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 221-09-2839	
17. INFORMANT Mrs Bertie Wilkins, wife, Bishop, Md.		Address 4201	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ASCVD (b) ASCVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Bishopville (County) Md (State)	
21. I certify that (I) this hospital attended the deceased from 1963 , 19, to 1966 , 19, that (I) we last saw the deceased alive on Feb 28 1966, and that death occurred at Bishopville M, from causes and on the date stated above.			
22a. SIGNATURE F. J. Townsend, Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) F. J. Townsend, Jr.		22d. ADDRESS Ocean City, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-8-66	
23c. NAME OF CEMETERY OR CREMATORIAL ODDFELLOWS COM.		23d. LOCATION (City or Town) Bishopville (County) Md (State)	
24. FUNERAL DIRECTOR O. Douglas Nelson, Frankford		ADDRESS DA MAY 12 1966	
25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	

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